Exclusive Vaccine Focus at Expense of Therapeutics Killed Up To 85% — Peter McCullough MD Testifies to HHS Committee

APR 14, 2021

Transcript

PETER MCCULLOUGH → 00:00

Good afternoon. I'm Dr. Peter McCullough and I'm an internist and cardiologist and professor of medicine at Texas A&M University School of Medicine. I'm on the Baylor Dallas campus, and I've been integrally involved in the response to COVID-19.

Now, the opinions expressed are those of my own, and not necessarily those of my institution. I can tell you that in my field, I'm an academic doctor, I see patients, but I'm very involved in research.

I'm the editor of two major journals. In my field, I'm the most published person – in my field, which deals with the heart and the kidneys – in the world in history. And when COVID-19 hit, I saw it as our medical Superbowl, and they were going to be doctors like Dr. Urso coming out of wherever they worked to face the virus. And there were doctors in the hospital that just had to receive the virus.

PETER MCCULLOUGH → 00:56

And then there were those who headed for the sidelines. And then there were those that were detractors against the pandemic. And so as I started to survey the literature, I had patients with heart and lung disease who needed urgent treatment. And I refused to let an illness which lasted for two weeks at home before they got sick enough, to be hospitalized.

I refused to let a patient languish at home with no treatment and then be hospitalized when it was too late. It was obvious. That was obvious in April, that that was the case.

So I used the best tools or drugs available at the time. And these are appropriately prescribed off label. Remember, a label is an advertising label, a label isn't a scientific document. There is an appropriately prescribed off-label use of conventional medicine to treat an illness.

And I, in May, I put together a team of doctors because the group that was facing the pandemic to the greatest degree was in Milan, Italy.

PETER MCCULLOUGH → 02:00

So most of them were in the <inaudible> Italian research network.

We summarized all we knew about the available drugs, and we published our findings in the August 8th issue of the American Journal of Medicine. And the title of that paper was the Pathophysiologic Basis And Rationale For Early Ambulatory Treatment. And it had a premise there's two bad outcomes to COVID-19, hospitalization and death.

The second premise, if we don't do something before the hospitalization, we can never stop it. We can never stop it. And I have to tell you when I, and was the lead author in that paper, but we had dozens of authors from Italy, India, UCLA, Emory. We had the best institutions in the United States.

I can tell you the interesting thing was there was 50,000 papers in the peer-reviewed literature on COVID. Not a single one told a doctor how to treat it. Not a single one.

PETER MCCULLOUGH → 02:51

When does that happen? I was absolutely stunned. And when this paper was published in American Journal of Medicine, it became a lightning ride. Oh my gosh, it became the most cited paper in basically all of medicine at that time.

The world started knocking on my door and I said, Oh my Lord. I just can't believe what became untapped. And I had never been on social media before. And my daughter who was home from law school, I was talking to her about it. She said, well, why don't make a YouTube video?

So I made a YouTube video with four slides from the paper. This is a peer-reviewed paper published in one of the best medical journals in the world, four slides. I even wore a tie and a suit, and she showed me how to record it in PowerPoint.

PETER MCCULLOUGH → 03:30

And I posted it on YouTube. It went absolutely viral. And within about a week, YouTube said you violated the terms of the community.

And that's when Senator Johnson's office got involved in Washington and said, Oh my gosh, this is important scientific information to help patients in the middle of this crisis. And social media is striking it down. Based on what authority?

Well, one thing led to another and I became the lead witness for the US Senate testimony on November 19th, 2020. And the reason why there was Senate testimony is because there was a near total block on any information of treatment to patients, a near total block.

And so what had happened over time is that we had gotten into a cycle in America of no information on treatment. Patients actually think that the virus is untreatable. And so what happens is they go out to get a diagnosis.

Now I'm a COVID survivor, my wife in the galley is a COVID survivor, my father in a nursing home is a COVID survivor.

You get handed a diagnostic test. It says, here, you're COVID positive, go home. Is there any treatment? No. Is there any resources I can call? No. Any referral lines, hotlines? No. Any research hotlines? No. That's the standard of care in the United States. And if we go to any one of our testing centers today in Texas, I bet that's the standard of care. I bet that's the standard of care. No wonder we have had 45,000 deaths in Texas. The average person in Texas thinks there's no treatment. They honestly think there's no treatment.

They don't even know about these EUA antibodies. You heard from a 90 year old gentleman who got bamlanivimab. Terrific.

Where's the focus? There's such a focus on the vaccine. Where's the focus on people sick right now? This committee ought to know where all these monoclonal antibodies are. They ought to know where all the treatment protocols are. They ought to have a list of the treatment centers in Texas that actually treat patients with COVID-19. So I led the initiative.

The second paper was published in a dedicated issue of Reviews in Cardiovascular Medicine. Now I had 57 authors, including Dr. Urso, Dr. Immanuel, lead doctors in Houston, San Antonio, all over. And it was another world by paper. And now we have it updated, integrated. So yes, we used drugs to affect viable replication.

PETER MCCULLOUGH → 05:50

The antibodies are terrific. We can use intercellular anti-infectives in that box. We use corticosteroids in inflammatory drugs. The best anti-inflammatory drug is colchicine. You've probably never heard about it. In the largest, highest quality randomized trial, over 4,000 patients, double blind randomized placebo controlled trial. There's a 50% reduction in mortality. No word of it, none, complete block to anybody, colchicine.

How can that be? How can that be? And then the most deadly part of the viral infection is thrombosis. So I have always treated my patients with something to treat the virus, something to treat the inflammation and something to treat thrombosis.

Just as Dr. Urso had. And I had very, very sick patients and I've lost two. But I have to tell you, what has gone on has been beyond belief.

How many of you have turned on a local news station or a national cable news station and ever gotten an update on treatment at home?

PETER MCCULLOUGH → 06:52

How many of you have ever gotten a single word about what to do when you get handed the diagnosis of COVID-19? No wonder that is a complete and total failure at every level.

Okay. Let's take the White House. How come we didn't have a panel of doctors assigned to put all their efforts and stop these hospitalizations? Why don't we have doctors who actually treated patients get together in a group and every week, give us an update. Why didn't we have that? Why didn't we have that at the state level? Zero? Why don't we have any reports about how many patients were treated and spared hospitalizations from all the – I listened to six hours of testimony today? Zero. Zero.

We have a complete and total blank spot on treatment. It is a blanking phenomenon. At least in the United States, there are some heroes. Now, the American Society of Physician and Surgeons took the lead. They're the group. They have identified 35 treatment centers in Texas.

PETER MCCULLOUGH → 07:49

They knew who they are. They have emergency hotlines. They helped Dr. Hall put together this very brief pamphlet, but there's more of an extensive one. We can pass it around to everyone that at least gives people half a chance to find out about information. Okay.

This is a complete and total travesty to have a fatal disease and not treat it. Now, the National Institutes of Health and the Infectious Diseases Society of America started putting out guidelines of the treatment of COVID-19. And to this date, they nearly exclusively deal with the hospitalized patient.

The two papers that I have published as the lead author, and supported by wonderful people, by Dr. Urso, are the only publications in the peer-reviewed literature that tell doctors how to treat

COVID-19 as an outpatient, based on the supportive scientific information. The only two.

The home treatment guide by the American Physicians and Surgeons is the only source of information available to patients on how to treat COVID-19 at home. The only source.

PETER MCCULLOUGH → 08:50

So what can be done right here, right now? There's going to be more people that die in Texas. And it's an absolute tragedy. How about tomorrow? Let's have a law that says there's not a single result given out without a treatment guide and without a hotline of how to get into research. Let's put a staff around this and find out all the research available in Texas. And let's not have a single person go home with a test result with their fatal diagnosis, sitting at home, going into two weeks of despair before they succumb to hospitalization and death.

It is unimaginable in America that we can have such a complete and total blind spot. I blame the doctors for not stepping up. Where was the medical society stepping up and putting effort on this? How about from the federal and state agencies? There never was a single bit of group collaborative effort to stop the hospitalizations.

PETER MCCULLOUGH → 09:39

Nobody even kind of thought about it. Bob Hall had me on a teleconference in April or May. And we're like, wait a minute. How come, where's UT Southwestern? I'm a graduate of UT Southwestern. Where's A&M? Where's the rest of the universities? How come we're not stopping this? How come we are not stopping this?

But it gets worse because in the paper I published in December of 2020, you know what I did. I had a terrific doctor from Brazil, we went through country by country, by country. And just asked the question, what are the countries doing? What was the last time you turned on the news and ever got a window to the outside world? When did you ever get an update about how the rest of the world is handling COVID? Never.

What's happened in this pandemic is the world has closed in on us.

PETER MCCULLOUGH → 10:23

There's only one doctor whose face is on TV now. One, not a panel. Doctors, we always work in groups. We always have different opinions.

There's not a single media doctor on TV who's ever treated a COVID patient. Not a single one. There's not a single person in the White House task force who has ever treated a patient. Why don't we do something bold? Why don't we put together a panel of doctors that have actually treated outpatients with COVID-19 and get them together for a meeting.

And why don't we exchange ideas? And why don't we say how we can finish the pandemic strongly? Isn't it amazing? Think about this. Think about the complete and total blind spot. So what happened? I can tell you what happened.

What happened in around May, it became known that the virus was going to be amenable to a vaccine.

All efforts on treatment were dropped. The National Institutes of Health actually had a multi-drug program. They dropped it after 20 patients, said, we can't find the patients. The most disingenuous announcement of all time.

And then Warp Speed went full tilt for vaccine development. And there was a silencing of any information on treatment. Any. Silencing. Scrubbed from Twitter, YouTube. Can't get papers published on this. You can't, we can't even get information out in our own medical literature on this. There's been a complete scrubbing.

So this program has been one of, try to reduce the spread of the virus and wait for a vaccine. And when we vaccinate, all efforts have to be on vaccination. And probably if I had four hours of vaccination on here. Think about it. As we sit here today, the calculations in Texas on herd immunity, the calculations are we're at 80% herd immunity right now with no vaccine effect. 80%. And more people are developing COVID today.

They're going to become immune. People who develop COVID have complete and durable immunity – a very important principle – complete and durable. You can't beat natural immunity. You can't vaccinate on top of it and make it better. There's no scientific, clinical or safety rationale for ever vaccinating a COVID recovered patient.

There's no rationale for ever testing a COVID recovered patient. My wife and I are COVID recovered. Why did we go through the testing outside? There's absolutely no rationale.

I'd encourage this committee to actually look at what's being done and ask, is there any rationale, is there any rationale for anything? Listen, there's plenty of COVID recovered patients. Let them forgo the vaccine and let people who are clamoring for it get it. But at 80% herd immunity in the vaccine trials, fewer than 1% in the vaccine and the placebo actually get COVID. Fewer than 1%. The vaccine is going to have a 1% public health impact. That's what the data says. It's not going to save us. We're already 80% herd immune. If we're strategically targeted, we can actually close out the pandemic very well with the vaccine, but strategically targeted.

People under 50, who fundamentally have no health risks. There's no scientific rationale for them to ever become vaccinated.

PETER MCCULLOUGH → 13:28

There's no scientific rationale. One of the mistakes I heard today as a rationale for vaccination is asymptomatic spread. And I want you to be very clear about this. My opinion is there is a low degree, if any, of asymptomatic spread. Sick person gives it to sick person.

The Chinese have published a study in British Medical Journal, 11 million people, they tried to find asymptomatic spread. You can't find it. And that's been one of important pieces of misinformation. When Senator Hall called a conference call of what should we do in the Capitol when we reopened, I said, you know what? You know what we do at Baylor? You walk in and they zap your temperature.

"One of the mistakes I heard today as a rationale for vaccination is asymptomatic spread. And I want you to be very clear about this. My opinion is there is a low degree, if any, of asymptomatic spread."

PETER MCCULLOUGH, MD

Professor of Medicine

You get a temperature check and go in. Do we test everybody who walks into the Baylor hospital? No. Are they a lot sicker than everybody in this room? You better believe it. So why would we do something here at the Capitol that has absolutely positively no scientific rationale and then do it in this context?

PETER MCCULLOUGH → 14:22

So my testimony as I sit here today is COVID-19 has always been a treatable illness. A very large study from McKinney, Texas, another one from New York City show that when doctors treat patients early, who are over age 50 with medical problems, with a sequence multi-drug approach with the available drugs, four to six drugs that are available to them now, the monoclonal antibodies are better. There's an 85% reduction in hospitalizations and death. 85%. 85%. I want you to remember that number. 85%.

"You can't beat natural immunity. You can't vaccinate on top of it and make it better. There's no scientific, clinical or safety rationale for ever vaccinating a COVID recovered patient."

PETER MCCULLOUGH, MD

Professor of Medicine

We have over 500,000 deaths in the United States. The preventable fraction could have been as high as 85%. If our pandemic response would have been laser focused on the problem, the sick patient right in front of us. We're focused over here and focused over there and focused on masks and what have you. Laser-focused. Sick patient, treat them. We lost focus on the most fundamental thing. That's my testimony.

CHAIR → 15:24

Thank you. I can tell how passionate you are and certainly have been a leader in talking about preventive protocols and also the ambulatory stage. And I do think that that has been missing and it's been a concern because COVID-19 is going to be with us, right? I mean, it's, you know, I hope we're at 80% herd immunity. I don't know yet. I'll read your papers, but I appreciate that. And the message is is that there are drugs out there that work. There are therapies out there that work.

PETER MCCULLOUGH → 15:54

But no single one works alone. And so the dismissive mistake was to do a very small study. Oh, we studied 200 patients and we used ivermectin, hydroxychloroquine, and it didn't work. That's like cancer and picking one drug and saying, Oh, it doesn't reduce cancer mortality. We never do that in cancer. We never did that in AIDS. We don't do it in hepatitis C.

What we look for is signals of benefit and acceptable safety. And then we combine them and that's all we've done. But this independent declaration drug by drug that the drugs don't work has been, and that's on us, that's been our medical house. That's been a giant error that we've made on our side. We never should have expected single drugs to reduce mortality, but drugs in combination against a fatal viral infection, we should have.

CHAIR → 16:39

This entire session is learned from lessons. I know we're running short on time. Senator Hall, you have one question or?

SENATOR HALL → 16:48

Real, real quick. I'd ask the question earlier when Dr. Hellerstedt was here about the idea that fits in with what you've talked about is that when we test someone, rather than just say, give them, yep. You're positive. You're negative. Be on your way. That we at least provide them information of what we know out there can be used.

Not trying to play the role of doctor out there. Would you, do you agree with Dr. Hellerstedt's interpretation that that should not be done because it's setting up a doctor-patient relationship and simply informing people or providing with over the counter drugs so that we could possibly have the early treatment for these folks rather than wait till they show up in the hospital?

PETER MCCULLOUGH → 17:40

We could at least have a physician group approved guide. The AAPS guide has been used in over 500,000 cases in the United States. In fact, the early treatment is probably what prevented us from overflowing the hospitals in the last quarter of the year.

"… when doctors treat patients early, who are over age 50 with medical problems, with a sequence multi-drug approach… There's an 85% reduction in hospitalizations and death."

PETER MCCULLOUGH, MD

Professor of Medicine

When I testified, I said, listen, we're on track. And I was very commenced to this. We're on track of overflowing our hospitals. Our break point was 135,000 in the hospitals in the United States, we hit 128. Now the curve started going down long before the vaccine.

So I can tell you herd immunity long before the vaccine showed up, started to go down. But the early treatment kicked up, ivermectin news skyrocketed, hydroxychloroquine, monoclonal antibodies, as much as we could push them. Sadly, the monoclonal antibodies are still sitting on the shelf in a lot of places, but committees like this ought to be saying, listen, where are those monoclonal antibodies?

PETER MCCULLOUGH → 18:28

Do we stock them at the nursing home? What are the big nursing home chains? What are the big urgent care chains in Texas? And what are they doing? What are their early treatment protocols?

You know, these are blank spots. I bet nobody here has even thought about this. This is really low hanging fruit that we can tackle. The bottom line is a lot of doctors have checked out. And when patients call them, they say, I don't treat COVID.

"People under 50, who fundamentally have no health risks. There's no scientific rationale for them to ever become vaccinated."

PETER MCCULLOUGH, MD

Professor of Medicine

And when I asked those doctors, I said, you don't treat COVID, how come? They go, well, there's no treatment. I said, but do you call them two days later to see how they're doing? No. So what's that? That's not, I don't treat COVID. That's, I don't care anymore. That's a loss of compassion.

So we have a crisis of compassion in our country, in the medical field. That's in our house right now. But for every doctor that's ever told a patient that they don't treat COVID. Okay. But do they call them two days later and help them get oxygen or see how they're doing?

If the answer's no, that's the Hippocratic oath going out. And that's on us. And I'm telling you, we have a real self-check to do in the house of medicine.

Dr McCullough MD
Peter McCullough, MD, MPH is board certified by the American Board of Internal Medicine in internal medicine and cardiovascular disease. He has extensive training and expertise in lipidology and echocardiography. He holds additional certifications from the American Board of Clinical Lipidology and the National Board of Echocardiography.

Dr. McCullough specializes in treating patients with complicated internal medicine problems that have affected important organs including the heart and kidneys. After receiving a bachelor's degree from Baylor University, Dr. McCullough completed his medical degree as an Alpha Omega Alpha graduate from the University of Texas Southwestern Medical School in Dallas.

He went on to complete his internal medicine residency at the University of Washington in Seattle, a cardiology fellowship including service as Chief Fellow at William Beaumont Hospital, and a master's degree in public health at the University of Michigan. Dr. McCullough oversees cardiology training, education, and research for Baylor Health Care System and is Vice Chief of Medicine at Baylor University Medical Center at Dallas. He is an internationally recognized authority in his field and frequently lectures on internal medicine, nephrology, and cardiology.

In addition, he has published over a thousand related scientific communications. He is currently serving as the chair of the National Kidney Foundation's Kidney Early Evaluation Program, the largest community screening effort for chronic diseases in America. As both a primary care physician and specialist, Dr. McCullough welcomes patients with complicated internal medicine problems that have affected important organs including the heart and kidneys.

He is knowledgeable about the roles of diet and exercise in health and disease and commonly provide guidance concerning dietary supplements and treatments for obesity. He has an intimate practice style with frequent patient contact and 24 X 7 access for questions and help with medical problems. His practice involves both teaching and research, therefore, his patients are among the first to have new tests and treatments for high cholesterol, high blood pressure, diabetes, and heart and kidney disease.

Dr. McCullough is on the medical staff at Baylor University Medical Center, Baylor Jack and Jane Hamilton Heart and Vascular Hospital, and The Heart Hospital Baylor Plano. He is also on staff at Baylor Heart and Vascular Institute which promotes cardiovascular research and education.

Peter McCullough has been censored by YouTube. The following four items will help the reader/listener broaden their understanding of the topics conveyed in this testimony by him.

COVID Treatment: Step-By-Step Doctor's Plan That Could Save Your Life, (Updated 1st Feb, 2021), Read PDF
Dr Peter McCullough MD Explains COVID19 Treatment Protocol (5th Nov, 2020), Watch Odysee
Treating Covid-19 @ Home with Elizabeth Lee Vliet, MD on The Dr. Peter Breggin Hour (18th Nov, 2020), Watch Odysee
Ambulatory Treatment of COVID-19. Peter McCullough, MD (12th Oct, 2020), Watch Odysee, Slides PDF